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ABSTRACT

This report reviews findings of research and clinical experience, which demonstrate clearly that addictive disorders differ in important ways between males and females. Addiction issues for women are highlighted including the prevalence of addiction, risk factors for women, and consequences of addiction. Also included are descriptions of women's treatment programs at the Caron Foundation, including the Adult Women's Programs and Adolescent Women's Programs. Specific treatment issues for women are discussed, such as barriers to treatment, characteristics of successful treatment programs, and research on treatment effectiveness. The report concludes with the "Caron Substance Abuse Scale for Women: 25 Questions about YOUR Alcohol and Substance Abuse." (Contains 12 figures and 56 references.) (GCP)

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Women & Addiction:
Gender Issues in Abuse and Treatment

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Excellence In Addiction Treatment

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The Mission of the Caron Foundation is to provide an enlightened, caring treatment community in which all those affected by alcoholism or other drug addiction may begin a new life.

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Foreword

By Sheila B. Blume, M.D.

I can recall the exact date I became interested in addictive disorders among women: September 9, 1962. On that day I began my psychiatric training at a large state-run psychiatric hospital on Long Island in New York. Like most physicians, I had learned almost nothing about addiction during my medical education, and I began my career without a working knowledge of these disorders. Not that we didn't treat alcoholics in medical school – we had learned most of our medicine and surgery treating alcoholic patients for the complications of their alcoholism, but we were never taught about how or why alcoholics drank or how to help them stop. Somehow it didn't seem to be our responsibility.

On the first day of my residency training, however, all that changed. I was assigned to a women's unit and presented with a list of names. These were my patients. Proceeding to interview them, I found a wide range of diagnoses. In school I had been taught that the accepted psychiatric practice was to sit and listen to patients, frequently, and for 50 minutes at a time. Since I had too many patients for this to be practical, I chose two to work with intensely, the one who seemed the most sick and the one who seemed the least sick. In my ignorance I selected an alcoholic woman as least sick. I soon discovered how wrong I was. I found that this desperate woman suffered from a severe and chronic illness for which there was no equivalent of Thorazine for the schizophrenic. I also found that there was little interest in helping such people. At that time, alcoholics within the state system were given the diagnosis "Without Mental Disorder; Alcoholism" and were supposed to be discharged as not in need of psychiatric care. In my efforts to help this patient I began a therapy group for alcoholic women. That group, in turn, was the beginning of a lifelong career in treating and studying addiction, especially in women.

I have had the pleasure of watching the Caron Foundation develop specialized programming for addicted women over the past several years. The findings of research and clinical experience, which demonstrate clearly that addictive disorders differ in important ways between males and females, have been incorporated into Caron's therapeutic system. This review of research documents much of the data that has influenced the formation of women's treatment at Caron. Although far more research is needed, what we have learned so far has helped thousands of women to recover and lead happy, productive lives. This has been accomplished in spite of intense societal stigma and a persistent lack of societal interest in helping female addicts. I am hopeful that this report on gender issues in abuse and treatment will add to our understanding and will help patients, families and the public reach a deeper insight into addiction in women.

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Addiction Issues for Women

Until recently the problem of women and addiction was hidden. Female alcoholics and drug addicts received little attention from treatment providers, researchers, and the general public. As Sheila Blume, M.D., an expert in the treatment of women and addiction, has noted, attention has focused on the problems of and treatment strategies for men[1].

In the 19th century when addictive drugs like cocaine and opium were legal, women were a major market for remedies based on these drugs. The opiate-based laudinum, a popular pain medication, and Coca-Cola syrup, which contained cocaine to increase energy, were very popular among female consumers[2,3]. Cannabis (marijuana) was often prescribed for gynecologic problems and headaches[3]. Although women openly used these drugs and often became addicted to them, often they were given diagnoses other than addiction. Even then, public concern about alcohol and drug abuse focused on men.

The issue of addiction and women could not stay hidden forever. Like men, women are vulnerable to drug and alcohol abuse and dependence. National surveys strongly indicate that drug use among women is increasing, often at rates higher than for men[2], even though men still are more likely to become addicted to drugs and alcohol than are women[4,5].

The trend toward "gender equality" in drug and alcohol use may be due to significant social changes in the past century. Women and even adolescent girls are no longer scorned for smoking or drinking in public. In fact, more adolescent girls than boys are beginning to smoke cigarettes. Although men continue to have more opportunities than women to obtain and use illicit drugs, drugs are becoming more available to women, increasing the chances that women will experiment and become addicted.

Prevalence of Addiction

The 2000 National Household Survey on Drug Abuse (NHSDA)[6] estimated that 7.7% of American men abuse illicit drugs, compared to 5% of American women – a gender difference of less than 3%. Approximately 4.5 million American women abuse alcohol, 3.5 million abuse prescription drugs, and over 3 million regularly use illicit drugs[7]. Women's rates of nicotine and alcohol consumption are approaching the rates of men[2]. Women's non-medical use of pain relievers, tranquilizers, stimulants and sedatives equal and often exceed men's abuse of these drugs[5,6]. By 1967 more than two-thirds of the prescriptions for tranquilizers and other psychoactive medications were written for female patients[3].

Most alarmingly adolescent rates of substance use by boys and girls appear to be equalizing. Nationally, adolescent illicit drug use is the same for boys (9.8%) and girls (9.5%)[6]. This also is the case for alcohol use. In 2000, 16.2% of boys and 16.5% of girls reported they used alcohol[6]. The use of some drugs may be becoming more prevalent among girls than boys. At the Caron Foundation, in 1999 adolescent female admissions for heroin dependence surpassed male heroin admissions[8].

Gender Differences

Although female drug and alcohol use is on the rise, it is important to realize that there are many major gender differences in use. Women are less likely than men to have ever used an illegal drug[5]. Men are more likely to be binge drinkers than are women[6] and to start using drugs and alcohol at earlier ages compared to women[4]. Men, also, are more likely than women to drink in social situations and in response to positive emotional feelings. Women are more likely than men to drink alcohol in isolation, when pressured by an alcoholic partner, or in response to negative emotions[9]. Men are more likely to have used a psychedelic drug and to have developed an addiction to alcohol and to marijuana compared to women[10]. Women alcohol abusers are more likely to report family histories of alcohol abuse and dependence than are male alcohol abusers[11].

Once they start, women tend to become addicted more quickly than men and to experience negative medical consequences sooner than men[4]. Animal studies have shown that female subjects begin to self-administer cocaine and heroin more quickly and use larger amounts of the drugs than do male subjects[12]. In addition, women's risk factors to addiction differ from men's risk factors. Also, the barriers to treatment experienced by women may make it more difficult for women to receive treatment compared to men.

Nicotine is an interesting example of gender changes in drug use. Although nicotine has been used since its early cultivation in the New World, it had been primarily used by men until the end of World War II[11]. Since the middle of the 20th century, women's use

of nicotine has increased to rates higher than rates for men. In 2000, 13.4% of adolescents reported smoking in the past month – 12.8% were boys and 14.1% were girls[13]. **Figure 1** illustrates that the rate of smoking by adolescent girls remains higher than the rate of smoking by boys.

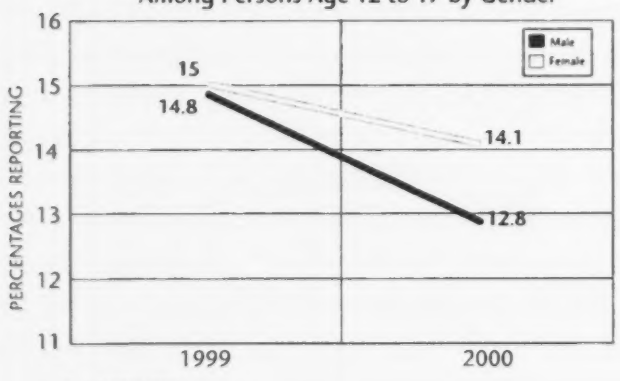
It also appears more difficult for women to quit smoking compared to men[14]. Recent research has found that women are more influenced by weight gain following cessation compared to men. A woman's withdrawal symptoms are influenced by her menstrual cycle, which may make her less responsive to nicotine replacement therapy than men. In addition, wives often are more supportive of their husbands' attempts to quit than husbands are to their wives' attempts.

Differences Among Women

Differences also exist among women that may impact their vulnerability to addiction and ability to receive treatment. For example, differences among women are clearly seen in alcohol consumption. White non-Hispanic women are more likely to consume alcohol than are African-American or Latino women, although African-American women who do drink, tend to drink more heavily and to have more alcohol-related problems than other women[5].

The degree to which an ethnic group has conformed to the dominant American culture is an important predictor of women's drinking across various ethnic and racial groups[15]. The more acculturated an ethnic-minority woman becomes, the more likely she appears to have positive expectations about alcohol and the more frequently she may drink in a wide range of social settings[15].

Figure 1: Past Month Use of Cigarettes Among Persons Age 12 to 17 by Gender



Source: NHSDA, 2000[6]

Age also is a strong predictor of female alcohol use. Young women have the highest rates of alcohol consumption and alcohol-related problems within the female population and tend to engage in binge drinking episodes more frequently than other age groups[15]. As seen in **Figure 2**, differences in primary drug addiction between adolescents and adults were greater than differences between adult women and men who were admitted to the Caron Foundation for treatment in 2000.

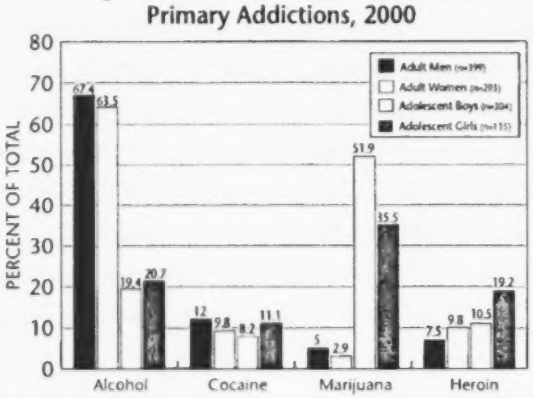
Another important indicator of drug use among women is geographic location. Different patterns of drug use are related to the availability of drugs in the specific neighborhood[16]. In addition, low household incomes, less education, and widowhood also are related to female alcohol abuse[5].

Risk Factors for Women

No one decides to become a drug addict or alcoholic. Instead, genetic, psychological, and social factors combine to make some women more vulnerable to addiction than others. Most researchers agree that some people have an inherited vulnerability to alcoholism and drug addiction. Much of the research has been conducted on male samples and it is difficult to generalize the findings to women. However, research has repeatedly indicated that women who have a family history of alcoholism are at risk for developing alcoholism[11].

Many experts in the field of women's studies view female development as a complex web of relationships[17]. Relationships can nurture and protect girls and women. They also can become destructive and lead to abuse and psychological problems, such as depression and anxiety. Relationships extend to one's peers, who can

Figure 2: Adult & Adolescent Patient Primary Addictions, 2000



Source: Caron Foundation

promote healthy behavior or impede it when peer pressure becomes more important than caring for oneself. The beneficial as well as negative powers of relationships may influence the behavior of girls and women more than they do boys and men.

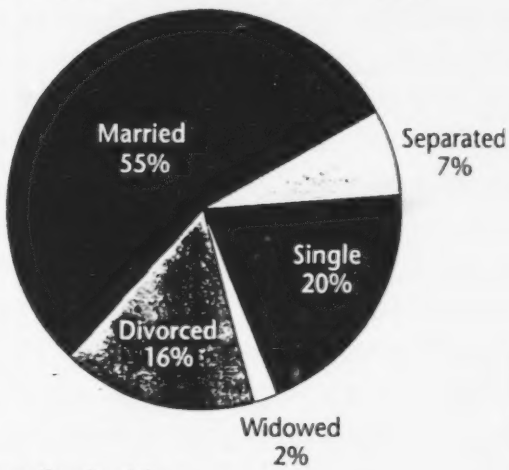
Intimate Relationships

From adolescence to old age, girl's and women's use of drugs and alcohol are influenced by the relationships in their lives[18]. Adolescent girls appear to be more vulnerable to peer pressure compared to boys[18] and may experiment with drugs and alcohol in order to feel accepted by peers. Female addicts and alcoholics also are more likely to have a substance-abusing partner than are male addicts and alcoholics[18]. It is estimated that one-third to one-half of women with addictions are living with a man who also is addicted to drugs or alcohol[19]. Women who are married to men who drink heavily also are likely to abuse alcohol[3]. As shown in **Figure 3,** over half of the adult women admitted to Caron Foundation for treatment in 2001 were married.

Young women tend to be introduced to drugs and alcohol by older men with whom they are intimately involved. At the Caron Foundation, approximately 25% of heroin-addicted female patients have been introduced to heroin by their intimate partners compared to less than 5% of the male patients[20]. As shown in **Figure 4,** female heroin-addicted patients also were more likely to be introduced to heroin by an opposite-sex friend compared to male patients who were more likely to be introduced to the drug by a same-sex friend or acquaintance.

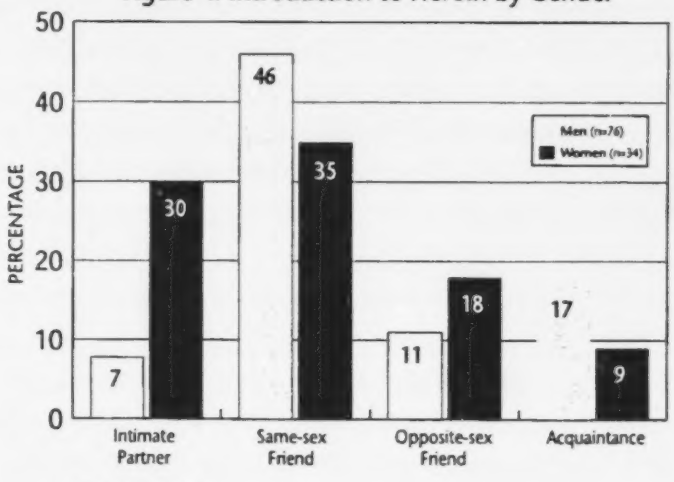
Likewise, the female patients were more likely to receive money to buy heroin and to support their drug habit from their partners than were the male patients. The women also were more likely to share needles with their partner than were men[20]. Other research also indicates that intravenous (IV) drug-using women are likely to have sexual activity with IV-drug using men[19]. These findings have important implications about women's vulnerability to drug use. Women tend to be introduced to drugs and alcohol through intimate relationships which can have potentially disastrous health consequences for women.

Figure 3: Marital Status of Adult Female Patients, 2001 (n=324)



Source: Caron Foundation

Figure 4: Introduction to Heroin by Gender



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Violence and Addiction

Violence can be physical and sexual. It occurs between strangers, intimate partners, family members and friends. Violence and addiction appear to be bi-directional – that is, a prior history of victimization may predispose a woman to drug and alcohol problems, and drug or alcohol abuse may be a risk factor for continued victimization[13]. A growing body of research concerning women addicted to drugs and alcohol shows that addicted and alcoholic women have experienced higher rates of violence than have other women. It is estimated that as many as 90% of women with drug abuse problems have been sexually abused at least one time in their lifetime[22]. Up to 40% to 74% of alcoholic women are reported to have suffered from some type of sexual abuse, such as incest or rape[21]. A recent study of women in treatment found that, prior to treatment, almost all the of study participants had been involved in violence as victims and/or perpetrators of verbal, physical and sexual abuse[23].

Women, in general, appear more vulnerable to violence in the family and within intimate relationships, while men seem to be more prone to violence in non-intimate situations[21]. Research on the types of violence experienced by adolescents in a psychiatric hospital found that the most common traumatic experience for boys was physical assault by peers, while girls most often reported being victims of unwanted sexual acts[24].

People who have experienced repeated violence or who have been victimized by a combination of physical and sexual violence appear to be at higher risk for substance abuse compared to others[22,25]. These individuals also seem to suffer more severe addiction and mental health problems. In a national study of addiction treatment programs, female patients who had been repeatedly sexually and physically abused were much more likely than other patients to have been in addiction and mental health treatment prior to the current episode and to have health problems, such as HIV/AIDS[22].

Sexual violence often begins as sexual abuse or incest in childhood. A national survey of women found that 21% to 24% of female alcoholics reported histories of childhood sexual abuse compared to 11% of other women[15]. Recent data from another national study of people in substance abuse treatment found that over 40% of female patients reported histories of sexual abuse and over half of these women reported that the abuse began prior to age 18[22].

Female alcoholics and addicts also are vulnerable to violence in adulthood. Female alcoholics are more vulnerable to the abuse of their alcoholic husbands and partners than are women who do not drink. However, the cause and effects of alcohol and violence are difficult to untangle. It is possible that after women drink heavily they are more vulnerable to violence by their partners, or that women drink after they are beaten as a way of coping with the violence[21]. Domestic violence is strongly related to underlying issues of power and control in relationships. Violence in the family is not directly linked to drug or alcohol abuse and, therefore, does not disappear with addiction treatment. Often an addicted perpetrator of domestic violence will require specific treatment to deal with issues of anger management.

Crime victims also are vulnerable to alcoholism. Research indicates that criminal victimization usually precedes an increase in alcohol use by crime victims[21,26]. A major study on adult women in the United States found there is a direct relationship between the number of times a woman has been victimized and the likelihood that she will become alcoholic[26]. In addition, women who abuse drugs or alcohol have a greater risk of repeated assaults than do other women[26].

Psychiatric Risk Factors

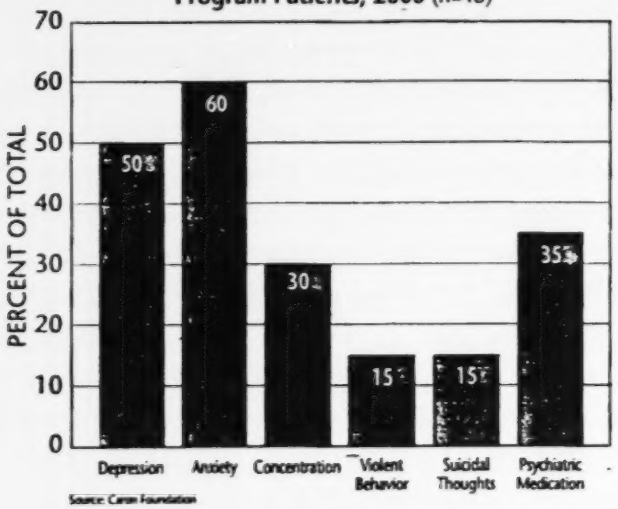
Women with addictions have higher rates of psychiatric problems compared to other women. Every psychiatric diagnosis is more common among female alcoholics compared to non-alcoholic women[5], although depressive or anxiety disorders appear to be the most prevalent diagnoses for chemically addicted women[1,9]. A national drug treatment study that compared the psychiatric symptoms of male and female patients found that the women were more likely than the men to have been diagnosed with an anxiety or depressive disorder and to have received prior mental health treatment for it [27].

Dr. Blume has noted that affective disorders, such as depression, may appear in women prior to substance abuse, while men are more likely to develop alcoholism first, which may lead to a secondary diagnosis of depression[1]. This difference has important implications for treatment, since a primary diagnosis of depression requires psychiatric treatment in addition to addiction treatment. A secondary diagnosis of depression, on the other hand, may remit through proper addiction treatment.

At the Caron Foundation in 2001, 48 female patients with chronic relapse problems were given a structured interview

concerning psychiatric symptoms they had experienced prior to treatment. Sixty percent reported anxiety symptoms and approximately 50% reported symptoms of depression. Almost 40% of the female patients had been prescribed a psychiatric medication prior to admission as shown in Figure 5.

Figure 5: Psychiatric Issues of Female Relapse Program Patients, 2000 (n=48)



Depression combined with drugs and alcohol can lead to high vulnerability for suicidal thoughts and behaviors. Over 15% of the female relapse patients at Caron reported thinking about death and suicide (see Figure 5). Alcoholic women are five times more likely to attempt suicide than are other women, and the suicide rates of alcoholic women equal those of alcoholic men[5].

Depression also is related to issues of self-esteem and self-image. Female substance abusers usually have lower levels of self-esteem and a poorer self-image than do male substance abusers[7].

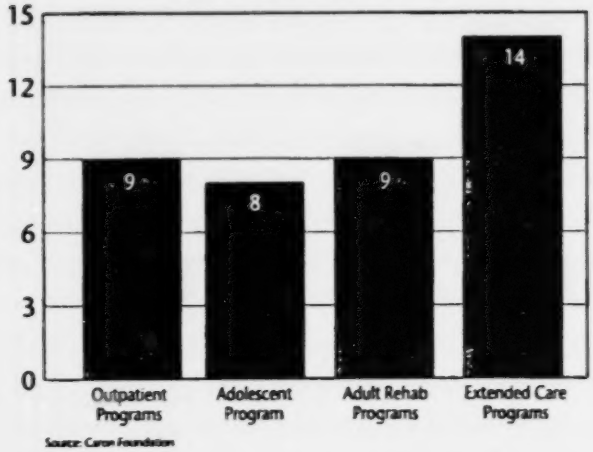
Similar to addiction, psychiatric problems are influenced both by heredity and the environment. For example, a person may be genetically influenced to develop major depression. However, it often requires negative events or experiences to trigger the depressive episode. As we have seen, women with addictions often have experienced major traumatic events of violence. In addition to high rates of addiction, a history of childhood sexual abuse predicts depression and anxiety, especially for women[15]. Female addicts in a national study who had histories of abuse were often preliminarily diagnosed with major depression and reported high levels of general anxiety and depressive symptoms, while male addicts were likely to be screened as having an antisocial personality disorder[25].

Posttraumatic stress disorder (PTSD) is a psychiatric condition that often follows the experience of a major traumatic event or an accumulation of traumatic events, such as witnessing violence or victimization. The traumas of sexual and physical abuse also are related to higher rates of PTSD compared to other types of traumatic experiences[22]. Individuals who abuse drugs and alcohol and have been victims of violence often suffer from PTSD. A national study found a direct relationship between a diagnosis of PTSD and later substance dependence[26]. Some research suggests the link between PTSD and addiction may be stronger for girls and women than it is for boys and men. PTSD may be more likely to develop when the victim has been traumatized repeatedly in intimate or family relationships, such as incest or marital violence[24]. Women with combined PTSD and substance abuse often suffer from extreme feelings of guilt, anxiety, self-blame, depression, suicidal thoughts and feelings, and dissociation[28].

In addition to experiencing high levels of anxiety and depression, women with addictions also appear vulnerable to other psychiatric conditions, such as eating disorders. In 1999, the Caron Foundation surveyed the 115 girls and women who were admitted to each of its treatment programs for symptoms of eating disorders[29]. Approximately 8% to 14% of the patients scored high enough on this screening to require a complete evaluation for bulimia, anorexia, or binge eating disorders, as shown in Figure 6. Other research has confirmed the high rate of eating disorders among addicted women, indicating that up to 40% of women with bulimia or anorexia also abuse alcohol and other drugs[5,30].

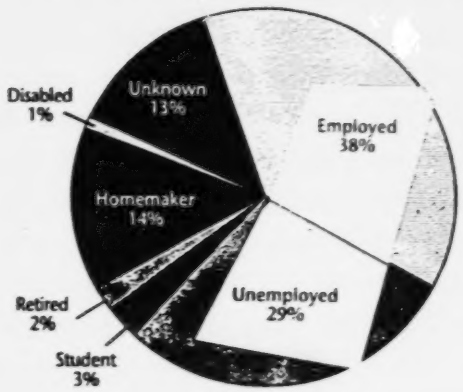
As with other disorders, eating disorders and addiction appear to be bidirectional. Some women develop an eating disorder and then abuse drugs or alcohol in response to their problems with eating, while others abuse drugs or alcohol and later develop an eating disorder in response to their addiction. For example, one woman who had been bulimic in her youth, switched to alcohol use because it decreased her appetite. When she was in early recovery at the Caron Foundation, the symptoms of bulimia reappeared. Another example is a woman who becomes addicted to cocaine, finds that she enjoys the experience of weight loss, and is unable to stop using the drug because she has developed the distorted body image prevalent among eating disorder patients.

Figure 6: Prevelence of Eating Disorders Among Female Patients, 1999 (n=115)



Source: Caron Foundation

Figure 7: Employment Status of Female Adult Patients, 2001 (n=408)



Source: Caron Foundation

Social Risk Factors

Social risk factors often involve the stereotypical ways in which women are viewed by others. These include social perceptions of women's roles at work and perceptions of women's sexuality.

Women who are employed outside the home report higher rates of drinking than do homemakers, although working women do not necessarily develop alcoholism[5,15]. While problems in the workplace are related to heavy drinking for men, employment itself appears to be a risk factor for women [31]. Risk factors associated with employment for women appear related to increased stress on the job, such as nontraditional occupations, low-status jobs, layoffs and unemployment, and part-time employment[11]. Women also traditionally assume multiple roles in addition to their paid employment that add to their overall stress[31].

Figure 7 illustrates the range of employmentstatuses among female patients admitted to the Caron Foundation in 2001. Over 60% of the female patients do not earn income through employment and less than 40% of them are employed.

Sexual promiscuity is a negative stereotype of substance abusing women. Stereotypes of women who drink and abuse drugs suggest that alcohol and other drugs stimulate a woman's sexual performance and are associated with promiscuity[32]. Many women also believe that alcohol increases sexual enjoyment[16,32]. However, research has shown that the more alcohol a woman consumes, the more likely she will have suppressed sexual arousal and orgasmic function[1,33]. Unfortunately, the stereotype that alcohol is an aphrodisiac may lead some women to drink in anticipation of sexual enjoyment.

Theories that drinking makes women less inhibited may be too simplistic to describe the complex relationship between alcohol and high-risk sexual behavior for women[15]. Instead of initiating sexual activity themselves, women who drink alcohol are more likely to experience unwanted sexual advances and aggressive behavior by other people who also are inebriated[32].

Consequences of Addiction

Medical Problems

Drug and alcohol addictions are a major health concern for women. In 1994, four times as many women were expected to die from addiction-related illnesses compared to breast cancer[3]. Substance abuse among women is likely to be related to other medical conditions, such as malnourishment, hypertension, and sexually transmitted diseases[7].

Health consequences of addiction are related to age. Drug and alcohol use by young, healthy girls and women is most often linked to accidental death, automobile crashes, overdose and suicide, while middle-aged alcoholic women are more vulnerable to breast cancer and osteoporosis, and older addicted women have a higher probability of falling and fracturing their hips[5,18].

Women also are more vulnerable than men to the negative

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affects of drugs and alcohol abuse. For example, women appear more likely than men to develop alcoholic hepatitis and cirrhosis of the liver, even when there are no differences in the amount or length of time the men and women had been drinking[5].

Smoking (with or without other substance use) presents many health hazards to women. It is the primary cause of lung cancer, which surpassed breast cancer as a cause of death for women in 1985[3]. Other cancers related to smoking include cancer of the larynx, oral cavity, esophagus, and cervix. Tobacco also increases the risk of cardiovascular diseases when it is used with medications like oral contraceptives. Its effect on pregnancy and birth will be discussed in the next section.

Using drugs intravenously, sharing needles with other drug users, and/or having unprotected sex with IV-drug users put a woman at great risk for diseases such as hepatitis and HIV/AIDS. By 1998, approximately 110,000 cases of AIDS had been diagnosed among American adolescent and adult women[7]. Women with AIDS are more likely than men to become infected with the disease through IV drug use (47% of women compared to 32% of men) or by sexual contact (19% of women compared to 2% of men)[12]. Once infected with HIV, women with approximately half the amount of the virus in their bodies as men will progress to full-blown AIDS in the same time as men[12]. HIV-infected women also are at greater risk than other women for cervical problems, gynecological infections, and sexually transmitted diseases[34].

Heavy drinking, cocaine or opiate use also negatively impact reproductive functions in premenopausal women either through drug interaction with hormones or through diseases associated with alcoholism, such as liver disease and malnutrition[35,36]. Compared to the general population, addicted women have higher rates of gynecological problems[37]. Reproductive problems include irregular menstrual cycles, early cessation of menstruation, and menstruation without ovulation[35,36]. Alcohol also negatively affects reproductive hormones in postmenopausal women and increases the risk of cardiovascular disease, alcoholic liver disease, or breast cancer[35].

The problem of osteoporosis or loss of bone mass has received much attention recently. Heavy alcohol consumption increases a woman's chances of this serious bone disease because it can result in inadequate absorption of calcium, which is essential for protecting healthy bones[35]. Also, many accidental falls and fractures are related to alcohol abuse[5].

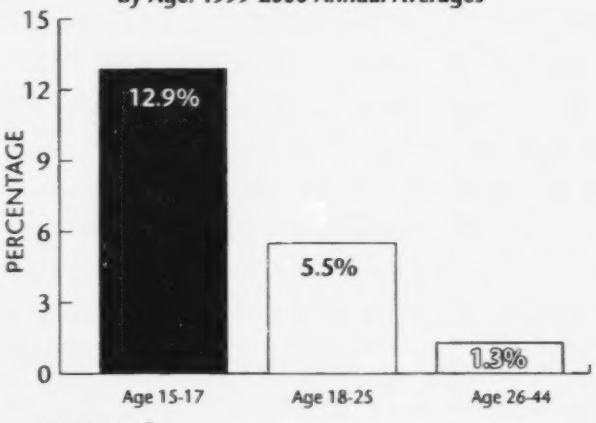
Pregnancy

Recent NHSDA[6] estimates of illicit drug use during pregnancy range from 1.3% of women aged 26 to 44 years to 12.9% of adolescent girls aged 15 to 17 years, as shown in **Figure 8**. Rates of drinking for pregnant women are 12.4%, with 3.9% reporting to be binge drinkers. Tobacco continues to be the most used addictive substance during pregnancy. In 1999 and 2000, 18.6% of pregnant women smoked cigarettes. In 1999, the highest rates of tobacco use during pregnancy were for the 15 to 25 year old age group[38].

Knowledge of the potentially devastating consequences of drug and alcohol use appears to have a positive affect on substance use behaviors of women during pregnancy. Except for the youngest group of pregnant adolescents, the rates of drug use during pregnancy are much lower than they are for non-pregnant women (7.7%). Non-pregnant women also have much higher rates of alcohol use (48.7%), with 19.9% binge drinkers. Although tobacco use among pregnant women is high, the rate of use is lower compared to non-pregnant women (29.8%).

Pregnant substance abusers who enter addiction treatment tend to be younger than other female patients[39]. They also have been found to have shorter histories of prior drug use and fewer prior treatment episodes than non-pregnant women. Pregnant women also are likely to be referred to treatment by another professional, such as a physician or nurse. Thus, pregnancy may serve as a critical trigger that compels women to enter addiction treatment[39].

Figure 8: Past Month Illicit Drug Use Among Pregnant Women, by Age: 1999-2000 Annual Averages



Source: NHSDA, 2000[38]

Most psychoactive drugs and alcohol cross the placenta easily and can negatively affect the developing fetus. In fact, a major concern of substance use and abuse during pregnancy is its potentially negative consequences to the fetus[40]. Direct relationships between specific drugs and problems during and post-pregnancy are difficult to establish because many women use multiple drugs, have other serious health problems, and do not receive adequate prenatal care. However, in utero exposure to drugs, such as alcohol, cocaine, amphetamines, heroin, and nicotine, is related to increased rates of spontaneous abortion, perinatal mortality, premature birth, low birth weight, and to developmental and behavioral problems in infants[40].

The effects of in utero exposure to alcohol have been known for almost 30 years[41]. Fetal alcohol syndrome (FAS) is the most preventable form of mental retardation and is caused by in utero exposure to alcohol. However, as many as one-third of infants born to women who have more than six drinks a day may have FAS[5]. It is characterized by abnormalities to the central nervous system and is associated with mental retardation and other behavioral, facial, and neurological abnormalities[5,41]. Alcohol-related neuro-developmental disorder (ARND) is diagnosed when the infant has brain damage following in utero exposure to alcohol, without other symptoms. One of the main difficulties in preventing FAS and ARND is that the exact time of fetal exposure to alcohol and the minimum quantity of alcohol required to produce negative fetal affects is not known[5,41]. Complete abstinence during pregnancy is recommended.

Many women who use drugs while pregnant do not tell their obstetric providers due to shame or fear of losing the child to the child welfare system. This fear of disclosure may have long-term negative effects on the mother and child if she continues using drugs. Drug use has been shown to impair the mother's ability to nurture and care for her children[42, 43]. Also, without treatment, abstinence during pregnancy does not always mean the woman will achieve long-term recovery from addictive substances. In fact, approximately 30% of mothers return to smoking cigarettes after delivery, and rates for new mothers returning to binge drinking (defined as five or more drinks on the same occasion) do not differ from the overall rate for non-pregnant women[38].

Social Consequences of Addiction

Substance abuse negatively affects women, as well as their children and families. Young female alcoholics experience high rates of assaults and victimization which may be due to violence in their homes and drinking in public spaces where they are made vulnerable to attack[18].

Women who abuse alcohol and drugs have been stigmatized as promiscuous throughout history by the public as well as by the scientific community[33]. Women inebriated by alcohol or high on drugs are seen as acceptable targets for sexual attack, and men who are sexually aggressive often rationalize their actions because they think the impaired woman wanted the sexual activity[1,33]. Middle-aged female alcoholics have greater rates of marital disruption compared to male alcoholics or non-alcoholic women[11,18].

Employed women who abuse or who are dependent on alcohol also suffer from problems in the workplace. Young women in their twenties who have blue-collar or other low-status jobs are likely to receive warnings from supervisors about their drinking[18].

In addition, arrests and incarceration of girls and women for drug-related offenses has increased dramatically in the past decade[2]. Arrests of girls and women for sale and/or possession of illegal drugs increased 42% from 1991 to 1996[2]. Crimes committed by women are more likely to be nonviolent when compared to crimes committed by men. These crimes often include shoplifting, selling drugs, and prostitution in addition to assault[5,44]. Incarcerated women often have children who are then raised by relatives or placed in foster care[2]. These children have an increased risk of drug and alcohol abuse[2].

Women's Treatment at the Caron Foundation

By Sharon Hartman, M.S.W., Director of Extended Care Services,
Michelle Staub, M.S., C.A.C. Diplomate, Coordinator of Adult Women's Primary Care Services
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Mission Statement

The Caron Foundation is committed to providing a comprehensive continuum of care that utilizes the most progressive treatment modalities to sensitively address the context of a woman's addiction and empower her individual recovery.

Philosophy of Care

The Caron Foundation believes that women's experiences of chemical dependency are different from men's experiences. This is the foundation upon which treatment and programming has been developed at the Caron Foundation. In 1996, the Board of Directors approved gender-separate and gender-specific treatment at Caron as part of the strategic plan. The special needs of women in addiction treatment are understood and supported by the staff.

The context of treatment at the Caron Foundation focuses on basic addiction treatment and relapse prevention. However, we employ a style of treatment for women which concentrates on empowerment and is oriented toward developing healthy relationships. This focus allows a woman to explore her issues, create options and then make decisions for herself. By learning to make healthy decisions, a woman can increase her chances of maintaining a fulfilled recovery. Through empowerment, a patient and therapist can foster and model a healing relationship, allowing the patient to be an active participant in her treatment. This focus also assists the patient in developing and maintaining her own support group and sponsor.

Overall, treatment needs to validate a woman's individual experiences, and encourage interdependence in relationships to reduce the isolation and shame created by addiction. A core value of addiction treatment is to increase the responsiveness to all of the patient's needs through the content and the context of the treatment programs.

Treatment Programs for Girls and Women

Adult Primary and Intermediate Women's Programs

The provision of specialized women's services is based on the awareness that a woman's experience in recovery may be different from a man's experience, and that it is important to address these issues in a safe and supportive environment. The adult inpatient programs help women who suffer with chemical dependency by providing gender-specific treatment rooted in the 12-step philosophy. The Caron Foundation made a conscious decision to develop two separate and distinct rehabilitation programs for women. Based on clinical experience, Caron decided that women who were new to addiction treatment and who had little or no experience with the 12-steps would benefit from gender-separate treatment in a Primary Care program. However, women who had previously attended addiction treatment and who had a history of sobriety and 12-step participation seemed appropriate for inclusion in the mixed-gender Intermediate Care program. Women who present for rehabilitation at Caron are carefully assessed before admission to one of the two programs.

Our first and foremost goal is to educate women that addiction is a disease, therefore reducing their feelings of shame and isolation. The stigma attached to women's addiction is a barrier to self-awareness of the problem. Basic addiction education is provided through mixed-gender psycho-educational lectures; however, a gender-separate process group follows the lectures to allow the patients to discuss the information in a safe and supportive environment.

Culturally, many women are socialized to be caregivers. As a result, it is imperative that family issues are addressed at the onset of treatment. This is done in order to aid in the development of a plan to treat the disease of addiction. This treatment process starts with a thorough assessment of chemical dependency as well as defining any other issues that may hinder recovery efforts.

For both the Primary and Intermediate care programs, therapeutic interventions are intended to assist women in understanding the internal and external factors that contribute to their addiction and that need to be addressed in order to attain quality sobriety. Women are encouraged to develop a heightened self-awareness, appreciation, and dedication to caring for themselves while validating their relationship needs and desire to help others. Women are encouraged to find ways to balance recovery with family, work, or social commitments.

Women's Extended Care Program (Rose Kearney House)

For many women, an extended stay in residential care can provide the opportunity to establish and practice new ways of managing and coping with their addiction. Rose Kearney House has long been dedicated to providing such an environment. Located off Caron's main campus, this extended care program provides a warm and supportive environment for women to continue their recovery process. In extended care, treatment is focused on helping women identify and develop interventions for their relapse triggers. Skills enhancement in such areas as stress management, assertiveness, communications, establishing and maintaining healthy boundaries, intimacy, developing a spiritual practice, and building a recovering network are taught and practiced

throughout the women's stay. Women are encouraged and supported in finding a 12-step sponsor and attending support meetings in the general community.

The therapeutic environment serves to enhance a woman's sense of safety, to strengthen her identity and worth as an individual and to support her in her efforts to grow in recovery. Individual therapy provides the attention and structure helpful in allowing a woman to explore painful issues and difficult recovery challenges. As treatment progresses, women begin to address such issues as parenting, work problems, and establishing and maintaining balance between self-care and responsibilities to others. Women are encouraged to seek employment, do volunteer work or take classes at a local facility.

Throughout the course of treatment in extended care, specialized services to address co-existing issues such as trauma, PTSD, depression and others are provided on an individualized basis. Continuing care is focused on developing a viable plan to meet each woman's needs. Consideration is given to each woman's responsibilities, her existing support network and her ability to follow-up with recommendations. This encourages women to continue in their treatment/recovery process allowing them to make a commitment and supporting them in their ongoing growth.

Adolescent Women's Primary Care Program

At Caron, adolescent women have responded well to gender-specific treatment. Interacting and problem solving with members of their own gender stimulates insight into individual and group needs. Young women are empowered as they learn how to identify internal and external resources and use these resources effectively. Adolescent women respond positively to the peer-group structure and consistency of a residential community-based program. They are provided with a safe place in which to work through sensitive issues as they explore their goals and personal values. What it means to be a woman in the scheme of things takes on new importance as choices and options are explored in preparation for the future.

Cognitive therapy and reality-based techniques are used to address adolescent belief patterns. An adolescent's black or white way of thinking is guided into a more realistic point of view, which promotes a willingness to make significant changes during treatment. Education about addiction and the concept of addiction as a disease helps young women understand the many consequences that result from drug and alcohol abuse. Working together, they are more able to take risks through loving interaction, which allows them to learn about themselves through feedback and support.

When adolescent females enter treatment for chemical addiction, they often bring with them a variety of co-existing conditions such as depression, a history of eating disorders, and self-injurious behaviors. Many of these behaviors temporarily disappear through drug use, because these young women self-medicate in an attempt to make their environment more manageable. However, during treatment and with the absence of drugs and alcohol, these co-existing behaviors often recur. As a result, a holistic approach to treatment becomes essential.

Caron recognizes that addiction is a family issue. Family participation in a female adolescent's treatment stay is deemed essential by the treatment team. Goals are set, including improved communication skills between family members, the ability of each family member to set limits for him- on herself and each other, and the honest identification of what each family member needs to change in order to promote family trust and healing.

A young woman finds a new feeling of hope as she learns to embrace her life rather than try to escape it. She is helped to experience her feelings and talk about them, not fear them. She learns to recognize that life is sometimes hard but more often exciting and rewarding and begins the process of moving from helpless victim to a place of empowered pride. She learns to enjoy being an adolescent, to have fun while sober, and to allow herself to love and be loved. This is the goal of the Caron adolescent treatment team who works with young women.

Young Women's Extended Care Program

The Young Women's Extended Care Program may be seen as a springboard from primary care to patient discharge into a more independent environment, such as home, school, or halfway house placement. Following a traditional inpatient primary care program, young women between the ages of 14 to 23 years are motivated to develop additional insight into their recovery needs and effectively utilize their acquired tools for recovery. A holistic approach, such as the one utilized in primary care, promotes continued physical, spiritual, and emotional healing. A focus is placed on the developmental needs of each young woman as well as issues resulting from their chemical dependency.

In the extended care program, these young women continue to identify the losses from and consequences of their addiction, and change their self-destructive behaviors into a more thoughtful approach to relationships between themselves and others. They confront behaviors that are not conducive,to recovery, and receive support in making difficult changes through the use of group feedback and honest responses to individual treatment progress.

Throughout her treatment stay, each young woman works not only to understand her place in the bigger scheme of things, but also to claim her right to get her needs met.

Family involvement is essential. A series of home visits helps patients to reintegrate into the family and a larger community system. During home visits, newly established boundaries are tested and then processed upon the patient's return to treatment, which allows difficult changes in behaviors and styles of communicating to be fine-tuned and implemented.

Treatment Issues for Women

Barriers to Treatment

Men are more likely than women to engage in addiction treatment. It has been estimated that only 30% of addicted women receive treatment[19]. Research surveys of the general public conducted between 1979 and 1990 found that men entered specialized addiction treatment facilities more than any other type of program, whereas women reported greater attendance of medical and mental health care programs more than alcohol treatment programs[45]. Other interviews with over 7,000 alcoholics found that 23% of the men compared to only 15% of the women had ever received addiction treatment[46]. Although no gender differences were found in access to care for the most severely alcoholic men and women, at average levels of severity, the research found that men were 50% more likely than women to engage in treatment for their alcoholism[46].

Obstacles that stand in the way of women receiving addiction treatment are known as "barriers." In order to increase the numbers of women who can benefit from addiction treatment, it is necessary to identify the barriers to treatment and to design programs that enable women to overcome these barriers.

In 2001 the Caron Foundation, the Betty Ford Center and Hazelden Foundation sponsored a series of national addiction conferences for women, known as the "Women Healing" conferences. These conferences were mainly attended by female therapists specializing in addiction and by women in recovery. In order to increase our knowledge of barriers to treatment, we designed a brief questionnaire that over 350 conference participants completed. As shown in Figure 9, the six most frequently identified barriers are social, treatment-program related, and psychological barriers[47].

Social Barriers

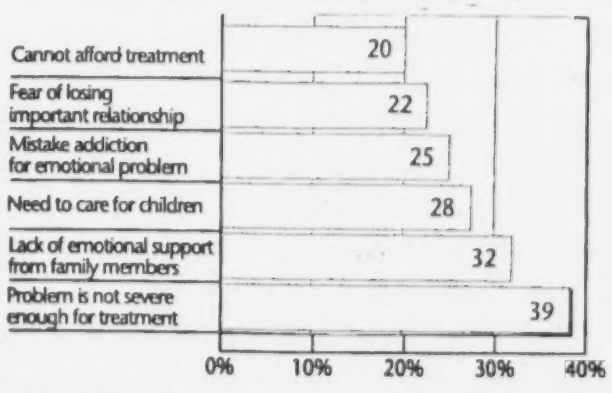
Social barriers to care involve societal and cultural attitudes toward addiction, the web of women's relationships, and roles of women as caregivers. An important difference between viewing addiction as a moral issue or as a disease is the issue of control. Society believes that moral human beings are able to control their impulses. Thus, unchecked aggression is condemned as immoral behavior. However, it is not possible to control a disease process. Individuals afflicted with cancer cannot stop its progress simply by will power or self-control.

Unfortunately, many people view addiction as a moral issue and not as a disease, and condemn the addict for not having the will power to stop engaging in immoral behavior. Female addicts and alcoholics, who are put on a high moral pedestal as wives, caregivers, and mothers, often are stigmatized more negatively than are male addicts and alcoholics[9]. Social attitudes that frown on female alcoholics and addicts are a major barrier to treatment[1,3,48]. Even women who realize they suffer from a disease have a daunting task to admit the problem to others. These women fear that their family, partner, or employer may hold the dominant social view of addiction as a moral problem and might not support their seeking treatment[49].

Additional barriers to treatment include embarrassment at discussing the problem with others and the fear that no one will be able to help[49]. In addition, Dr. Blume has noted that health care providers, such as physicians, often fail to diagnose drug or alcohol problems in women because their female patients do not resemble social stereotypes of addicted women[1].

Relationships with an intimate partner are very important to women. As mentioned earlier, many addicted women are in relationships with partners who also are addicted to drugs or alcohol and who are resistant to treatment for themselves or their mates[27,46,48]. Because women are heavily influenced by their partners' attitudes

Figure 9: Barriers to Treatment (n=356)



Source: Caron Foundation

toward treatment, these women often fail to seek treatment. Conversely, women in relationships with addicted partners are likely to encourage their partners to seek treatment and support them during rehabilitation[27].

Childcare responsibilities and other obligations at home can also impede addiction treatment[50]. Childcare is an issue that has been identified in a number of research studies[9,36,48]. Women often cannot afford to pay for childcare while they are in treatment, regardless of whether the treatment is long-term residential, day treatment, or hourly treatment sessions. They often feel guilty about burdening family or friends with caring for their children and worry about the safety of child care facilities. In addition, some women do not seek treatment for addiction because they fear that open knowledge of the problem could be used against them by the child welfare system to remove their children from their home[27,50].

In addition, other relationships, such as friends or family, may be less supportive of treatment for women compared to men. A national study of women in addiction treatment found that women were less likely than men to report that friends and family had encouraged them to abstain from drug use[27].

Treatment Program Barriers

Treatment programs often unintentionally create barriers to treatment for women. These include financial barriers, bureaucracy, male-focused treatment, and lack of sensitivity toward women with addiction.

Treatment is not free. It usually is financed by a combination of private pay by patients and their families, insurance coverage, grants, charity, and public funding. Many women who need addiction treatment are unemployed and do not have health insurance. However, even if women have insurance, the cost of treatment can still be a major barrier because insurance often does not cover all of the treatment costs. Furthermore, women seeking publicly funded treatment find that treatment slots are in short supply[49,50].

Interviews with chemically-addicted women also highlight "red tape" or complicated bureaucratic protocols as another barrier to treatment[48,50]. Waiting lists for admission appointments and treatment slots, inconvenient times for appointments and treatment, and unnecessary forms and documentation decrease the likelihood that women will follow through on their initial impulse to get help. Programs that are located in areas distant from public transportation and that do not provide childcare also create barriers to women in need of these services[19]. In addition, some programs that utilize medications as part of treatment refuse to treat pregnant women or women who do not use birth control because of possible risk to pregnancy[19].

There also is some evidence that staff characteristics affect the engagement of women in treatment. Programs that train their staff to be sensitive to gender-related issues, such as the risk factors mentioned earlier, may be more successful in attracting women to treatment than traditional gender-neutral programs[9,19].

Psychological Barriers

It would be impossible to live in a society and not to absorb some or most of its values and attitudes. These internalized perceptions and attitudes can become psychological barriers to treatment. Many women have internalized the prevalent view that addiction is a moral failing and avoid treatment because they think they can develop the self-control or will power to control their drug or alcohol use[49]. They also experience much shame about their addictive behaviors and avoid treatment as a way of hiding the shame[9,50].

Society also has the male stereotype of the "Skid Row Bum," or public inebriate, as its main model for addiction. This model does not even fit most men, let alone women, who are more likely to drink in the privacy of their homes[1,46]. When this stereotype becomes internalized, women may not pick up the cues that they have a chemical addiction. A major barrier to treatment is lack of awareness of the severity of the addiction[27,49].

Women are more likely than men to mistake the symptoms of addiction for psychiatric or medical problems[27,49] or as a response to stress[9]. The lack of knowledge of symptoms of addiction creates a barrier because women tend to seek treatment through the mental health system instead of through addiction treatment facilities[9,11,27,45]. Men, on the other hand, are more likely to be ashamed of seeking mental health treatment and are more likely to view their problems as addiction-related[9].

Finally, most people find it difficult to change their behavior. This is especially true for behaviors that have strong biological, environmental and psychological components, such as drug and alcohol addiction. People generally become addicted because at first the drugs made them feel better than they felt without the drug. Even after the good feelings have disappeared, cravings or a desire to

feel "normal" may keep the person using the drug. Fear of life without drugs begins to mean more to the person than living drug-free. Living life without drugs also implies making major life-style changes, and, because making such changes is difficult, resistance to change becomes a barrier to treatment[48,49].

Successful Treatment Programs for Women

Successful treatment programs for women are designed to address major risk factors, consequences of addiction, and barriers to care for women. The National Institute on Drug Abuse[51] has identified a wide range of services that have proven to be effective supplements to addiction treatment for women. These services include the following:

- Food, clothing and shelter
- Transportation to treatment
- Child care during treatment
- Job counseling and training
- Legal assistance
- Literacy training and other educational skills
- Parenting skills training
- Family and couples therapy
- Medical care and family planning services
- Social support services
- Psychiatric assessment and mental health services
- Assertiveness training

It is not realistic to expect that all treatment centers provide identical care and services to women. As illustrated earlier, female cultural and age differences affect their risks for addiction as well as addictive behaviors. It is important, however, for treatment programs to be aware of the major gender differences in addiction, and to identify the most prevalent problems facing the female populations that they serve. In this way, a variety of different treatment programs can be designed to meet the specialized needs of addicted women and girls.

Gender Sensitivity in Treatment

Many mixed-gender programs provide effective care to women. What distinguishes these successful programs is their sensitivity to women's issues, characteristics of the treatment staff, and continuing relationships with patients.

Often treatment programs that are sensitive to women's issues utilize mainly female professional staff[52]. However, the Caron Foundation offers both gender-separate and mixed-gender programs for women. The decision-making process that led Caron to develop and maintain two separate and distinct women's programs is described earlier in the section "Adult Primary and Intermediate Women's Programs" section, which describes Caron's services to women. The women in the mixed-gender program tend to be in treatment for chronic relapse issues, while the gender-separate program serves women who have not had prior addiction treatment. In 2000, we interviewed 13 female patients in the gender-separate program and the mixed-gender program[53]. Regardless of the treatment program, many of the female patients reported a preference for female therapists because they thought that other women would be more sensitive and responsive to their needs.

The attributes of successful therapists often are not related to gender, but to other qualities. Female addiction patients who completed a couple's therapy component of a drug treatment program reported that helpful therapists were supportive, caring and concerned[48]. These therapists also were able to direct the therapy sessions without appearing to be controlling or confrontational.

Research also suggests that a continuing relationship with the treatment provider is an important component of treatment, especially for women[51]. During a slip or a relapse, it is very important for the woman to be able to address her concerns with supportive staff with whom she has already developed a trusting relationship.

Dr. Stephanie Covington, a researcher and clinician concerned with women's addiction, developed a relational model of addiction treatment for women[17] based on a sensitivity to the importance of relationships in female development. Its philosophy of care posits that women recover in environments that are characterized by interpersonal safety, connection to one's treatment provider, and empowerment through appropriate use of power by the clinician. The philosophy of care at the Caron Foundation's treatment programs for women is similar to this model of treatment.

Gender-Separate Programs

Traditionally, chemical addiction programs have not distinguished between gender and have provided the same treatment services within the same program both to male and female patients. Some programs even provide gender-mixed recreational services and

dormitories. Based on new theories and evidence that women and men differ in developmental as well as addiction issues, some treatment programs have instituted gender-separate programs in order to focus more directly on specific gender issues.

Some women prefer an all-female environment because it decreases problems of heterosexual attraction and sexual harassment. Also, traditional mixed-gender programs often have more male patients than female patients, and men tend to monopolize these group therapy sessions. In such groups, women tend to yield both to men and women when they are interrupted while men tend to stop talking only if another man interrupts them[52]. Consequently, women tend to express themselves more frequently in female-only groups where interruptions are far less frequent.

Gender-separate treatment programs also may facilitate therapeutic discussion of sensitive topics, such as physical and sexual abuse[2]. In addition, gender-separate therapy programs may promote therapeutic discussions with women about how they differ from men in their views about addiction and recovery.

When the Caron Foundation interviewed the female patients in its gender-separate and mixed-gender program[44], we found that the women viewed the male patients as "action oriented" and focused on themselves. Alternatively, the female patients described themselves as being reticent to speak and sensitive to the needs of others. Female patients also felt that men experienced the consequences of addiction differently from women. One patient described the male view of a DUI as a "badge of honor," that women would be ashamed of, "especially if we have children in the car." In addition, unlike men, the women did not differentiate their addiction issues from other concerns and felt that it was important to understand the interplay of addiction and issues such as abuse, work, and relationships, in order to promote recovery.

Although 12-step programs, such as Alcoholics Anonymous (AA), do not consider themselves to be treatment programs, they are very helpful to people who want to maintain long-term sobriety. Approximately 35% of AA members are women[5], and in 1990, 80% of women who had received formal addiction treatment attended AA meetings[45]. AA is the most frequently utilized treatment approach for female alcoholics[5]. AA and other 12-step programs recognize the benefits of gender-separation and in many communities offer separate meetings for men and women.

Gender-Specific Enhanced Services

Although both men and women suffer from the same disease of addiction, gender plays a significant role in the development of addiction. Gender-specific services are designed to address gender-related issues of addictive processes and barriers to care. Addressing other psychosocial issues while the woman is in addiction treatment may favorably impact the treatment because it gives the woman increased resources which enable her to better focus on her addiction issues. For example, a woman suffering from flashbacks of trauma, may have an increased ability to abstain from drugs and alcohol if she receives PTSD treatment that teaches her how to contain the prior trauma.

Areas of gender-specific enhanced services include medical and health care issues, emotional and psychological issues, life skills, partner and parenting skills, and services directed to culturally specific populations[37]. The addiction treatment center can provide these additional services as part of a comprehensive treatment plan or it can facilitate access to community-based services while the patient is in addiction treatment or as part of a comprehensive after-care plan.

Women tend to become medically compromised more quickly and differently than male addicts and alcoholics. In addition to screening for major medical problems affecting people with addictions, such as tuberculosis, hepatitis, and HIV/AIDS, programs for women also address reproductive health issues and concerns. Pregnant women often are identified with drug or alcohol addiction during routine pre-natal medical check-ups and require addiction as well as obstetrical, family planning, and pediatric services. Special pre-natal addiction programs located as part of the obstetric service or within the clinic setting are able to address the woman's addiction and obstetrical issues[19].

Psychiatric services also are an important component of care for addicted women. Untreated psychiatric problems are among the main reasons for relapse to addiction. Early assessment and diagnosis of co-occurring psychiatric illnesses, such as depression and anxiety, can be a crucial component of care. Therefore, it is important for the women also to receive separate treatment for their psychiatric problems in addition to addiction treatment[1].

Many treatment centers provide psychiatric services on site, while others refer patients to external resources. Specific treatment interventions have been designed and tested that address both

psychiatric and addiction issues. One such intervention is group therapy for women with PTSD and substance use disorder[28]. The group is designed to educate patients about PTSD and addiction, and to improve the patient's daily life structure, coping skills, affect management, and self-care. Programs such as this do not replace addiction treatment, but are designed to help women make more effective use of other treatment they may be receiving.

Female alcoholics and addicts tend to be unemployed and have lower educational and vocational skills than men[19]. Therefore, some treatment programs for women offer added classes in vocational training, high school education, and independent living skills[5].

Addicted women who are parents face major difficulties when seeking treatment. To meet ongoing child care needs, some outpatient treatment programs have developed on-site childcare services, and specialized residential programs for pregnant and parenting women, which allow babies and young children to remain in treatment with their mothers. On-site childcare is one of the most useful services to increase attendance at treatment programs[19]. However, parenting women may need more than basic childcare services. Some programs have developed specific classes in parenting skills and child-parent relationships[5].

Intimate relationships also have been shown to be very important to women. An older man in a woman's life is likely to be the person who introduces her to drugs. A woman's male partner is likely to oppose or be unsupportive of her treatment. Men also are likely to be the perpetrators of childhood sexual abuse, rape, and spousal abuse. Treatment programs for women have developed specific interventions and services to address these issues. Programs often screen male partners for addiction and spousal violence[5]. They also may offer family education programs to educate the partner about addiction and recovery as well as couples therapy to address underlying psychological issues of the couple. Treatment programs that are effective in engaging the woman's substance-abusing partner into addiction treatment also may have better retention and recovery rates than programs that do not address the partner's addiction[19].

Comprehensive treatment programs for women combine many of these services within one treatment program[39]. In such programs, patients generally receive a wide range of medical, psychiatric, and social services in addition to basic addiction treatment. Comprehensive treatment programs that are outpatient or day treatment programs often provide transportation and liaison with community-based organizations to meet basic food, clothing, and housing needs[19]. These comprehensive programs are specifically designed to meet the needs of lower socioeconomic women, whose multiple needs often are not met by the bureaucracy of social service agencies[40].

Comprehensive programs may be especially important for lower income pregnant women[43]. One such program, the Center for Addiction and Pregnancy in Maryland provides its pregnant patients with obstetrical treatment, family planning counseling, occupational assessment, parenting, and family therapy as well as addiction therapy through individual drug abuse education, family member drug abuse education, and relapse prevention groups[40].

Treatment Effectiveness – Does Treatment Really Work?

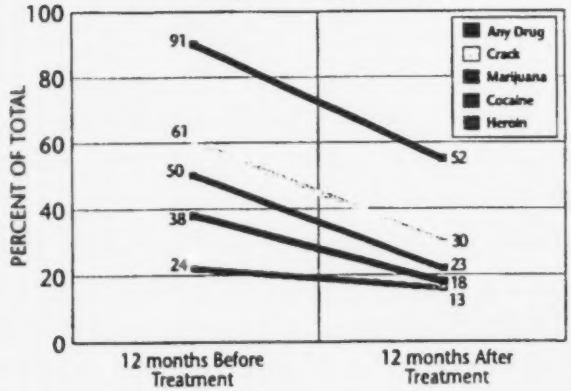
As shown, girls and women receive substance abuse treatment in a variety of settings, from traditional mixed-gender and gender-sensitive programs, to gender-separate and gender-specific programs. Since the focus on women's addiction issues is relatively new, not much research has been conducted to evaluate the effectiveness of these various types of programs. This section highlights research evaluations of addiction treatment for women.

Treatment Versus No Treatment

A national evaluation of a wide variety of treatment programs, such as outpatient, methadone, drug-free, short-term residential and long-term residential programs, has shown that treatment is effective for women[44]. In the year following treatment, women had reduced their levels of drug and alcohol use, reduced criminal activity, reduced use of public assistance, and increased employment. **Figure 10** illustrates the decreases in illicit drug use.

A meta-analysis is an analysis of a number of separate research studies. A recent meta-analysis of scientifically conducted research on addiction treatment for women analyzed the results for over 33 research studies conducted between 1966 and 2000[7]. The evaluation concluded that treatment generally is effective for women. Treatment decreases alcohol and drug use, psychiatric symptoms, and criminal behavior. It improves a sense of psychological well-being, HIV risk-reduction behavior, and birth outcomes. Addiction treatment also changes psychological attitudes and beliefs in a positive direction.

Figure 10: Pre- and Post-Treatment Drug Use Among Women



Source: Center for Substance Abuse Treatment [44]

Treatment also appears effective for women with very different pretreatment histories. Women with histories of physical and sexual abuse often have higher psychiatric and other problems compared to other women. A recent analysis of sexually and/or physically abused women who were treated in the past year, found no differences in post-treatment drug and alcohol use between women who were abused once versus women who suffered severe abuse over a period of time[22]. One year following treatment, substance use had declined significantly for women in all groups, from those who had been physically or sexually abused one time, to those who had been repeatedly sexually abused, to those who had been repeatedly abused both sexually and physically. Indicators of mental health, employment, and criminal behavior also showed improvement across the types of female patients.

Gender-Separate Versus Mixed-Gender Programs

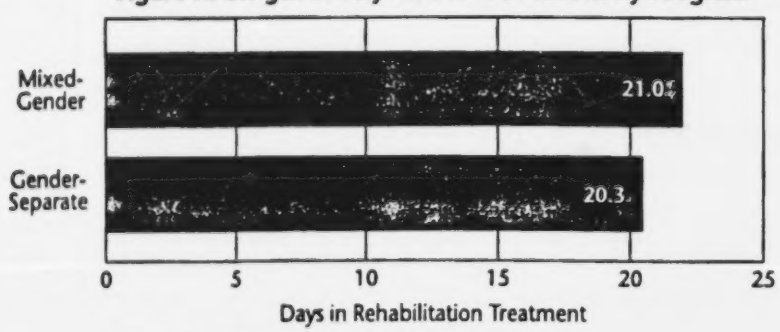
Evaluations of gender-separate versus mixed-gender programs tend to show that female patients drop out sooner from mixed-gender programs compared to gender-separate programs[5,19]. An evaluation of a mixed-gender program that was sensitive to women's needs found it, too, had dropout rates comparable to a traditional mixed-gender program[52].

A comparison of over 4,000 women in gender-separate or mixed-gender publicly funded chemical addiction treatment programs found significant differences, pre- and post-treatment[39]. Even though the women in the gender-separate programs tended to have higher substance abuse, and more psychological and social problems than women in mixed-gender programs, they stayed in treatment longer and were more than twice as likely as the women in mixed-gender programs to complete treatment.

Benefits to female patients in gender-separate programs compared to mixed-gender programs also have been shown in terms of subsequent decreases in drug and alcohol use and increases in social functioning[5,19]. The recent meta-evaluation of treatment evaluations concluded that gender-separate programs are more likely than mixed-gender programs to provide treatment benefits[7]. These results give support to experts who think that gender-separate programs best meet women's needs.

However, some mixed-gender programs have comparable lengths of stay to gender-separate programs. Approximately 140 female patients in the mixed-gender program at the Caron Foundation in 2001 had an average length of stay of 21 days compared to an average 20.3 day length of stay for 265 female patients in the gender-separate program, as shown in Figure 11.

Figure 11: Length of Stay for Female Patients by Program

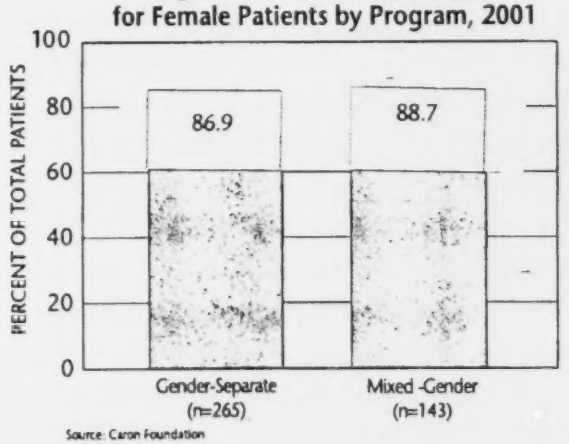


Source: Caron Foundation

Likewise, in 2001 there was no difference in type of discharge between the women in the Caron Foundation mixed-gender program and gender-separate program. Approximately 89% of the 143 female patients in the mixed-gender program were routinely discharged or transferred to another Caron program, compared to 87% of 265 female patients in the gender-separate Primary Care program, as shown in Figure 12.

These discharge rates for routine discharges are very similar to the rates experienced by men in the male Primary Care (m = 82.4) and Intermediate Care (m = 84.0) programs. The similar lengths of stay for Primary and Intermediate Care women and men may be related to the initial assessment process conducted on all patients at admission. Prior to placement in a rehabilitation program, patients are carefully assessed to determine which program is the appropriate placement for them.

Figure 12: Routine Discharges for Female Patients by Program, 2001



Source: Caron Foundation

Gender-Specific and Enhanced Services Treatment

Gender-specific service enhancements appear to be effective in engaging and retaining female patients[5]. The results of the meta-evaluation of women's treatment programs concluded that adding women-specific services and treatment components to addiction treatment increases the value of the treatment program for women[7].

Residential programs that allow female patients' children to remain with them in treatment appear to have higher retention rates than similar programs that do not provide living arrangements for children[19]. An evaluation of a residential therapeutic community treatment program for women found significant differences between the women randomly assigned to live with their children and the women whose children lived with relatives or friends during treatment[54]. Before entering treatment, these women had histories of severe drug use, trauma, and arrests or imprisonment. Six months following completion of the program, the women assigned to live with their children were more likely than the other women to report abstinence from drugs and alcohol, involvement in aftercare or support groups, employment, custody of children, and no arrests or incarceration.

Treatment enhancements often add to the financial cost of treatment, but may prove to be cost-effective. One recent study found the combined cost of addiction treatment and infant care in neonatal intensive care units (NICU) was lower than the cost of NICU for women who had not participated in addiction treatment[55]. The pregnant women who received addiction treatment also had better clinical outcomes at delivery compared to the other women, including lower levels of drug use, and healthier infants.

Matching Treatment to a Woman's Needs

Research studies in addiction treatments strongly indicate that patients are best served by programs that meet their specific needs. The meta-evaluation of women's treatment concluded that the value from the enhancements depend on their appropriateness for the women in the treatment program[7]. Women with histories of abuse most likely would have a better prognosis of recovery in programs that address the mental health and social consequences of abuse, in addition to basic addiction treatment, than they would in traditional programs that focus solely on addiction treatment. Likewise, low-income women who often cannot access services to meet their basic needs may require addiction treatment that utilizes a comprehensive treatment approach that includes a wide range of medical, psychiatric, and social services in addition to basic addiction treatment.

It is important to learn about a program in order to select the best one. Women need to conduct an honest inventory of their needs and strengths and choose a program that has additional services or can link them to the supplemental services to address those needs. For example, a woman whose work environment triggers impulses to drink may require vocational counseling to promote her recovery. However, it may not be necessary for the

addiction program to supply the vocational counseling if the treatment program is able to assess her vocational needs and make an appropriate referral to outside vocational services. Thus, the vocational component of her recovery plan may be addressed after she completes a residential program or through a separate program from her outpatient treatment.

Since there still is an insufficient body of research to determine if gender-separate treatment is more effective than mixed-gender treatment for all women, it is necessary for each woman to conduct her own personal assessment of what works best for her. At the Caron Foundation, 53 female patients expressed different degrees of concern with issues of comfort with men in groups. Many women expressed a high degree of comfort in mixed-gender therapy groups, while other women wanted or were grateful for the opportunity to explore their issues in therapy groups comprised only of women. The female patients generally were positive about the gender-separate dormitory facilities at Caron. One woman in the mixed-gender program compared her comfort level at the dormitory to her home when she said, "It feels like I'm home when I'm at the woman's dorm."

Are Drugs and Alcohol Causing You Problems?

Women often do not recognize they have a problem with drugs or alcohol or they mistake the symptoms of addiction for other emotional issues. In order to identify an addiction problem it is necessary to examine your own use of alcohol and drugs[56].

Honestly examine whether or not drug or alcohol use is causing problems – to yourself and/or your relationships. Compare your behavior to the observations of experts. Become aware of the effects that drugs and alcohol have on your physical and psychological functioning to determine if these problems, such as depressed mood or sleep disturbance, are due to drinking or drug use. Identify the times you are most likely to use drugs or alcohol to ascertain if use goes up during times of stress, a common symptom of addiction. Develop other, more productive ways to handle stress and to cope with high-risk situations.

If you think you may have a problem, try to stop using drugs and alcohol completely for at least six months. Women who find excuse after excuse for continuing to use drugs or alcohol often realize they are addicted. Women who are able to successfully stop use for a long period of time often find that they function much better without the drugs in their systems. It is easier to prevent or minimize the long-term consequences of addiction if you stop the process earlier rather than later!

Most important, remember that addiction treatment works better than no treatment! Break through your denial and shame and seek help. Find the treatment program that meets your needs and begin the journey to recovery.

If you think that you may have a problem with drugs or alcohol, complete the brief questionnaire found at the conclusion of this report, or give it to a friend or family member whose behavior around drugs and alcohol concerns you. Remember that untreated addiction negatively impacts women much more quickly than it affects men and can destroy a woman's life. And also remember, that treatment does work!

Caron Foundation Substance Abuse Scale for Women: 25 Questions About YOUR Alcohol and Substance Use

by Eileen Beyer, Psy.D., C.A.C. Diplomate,
Susan Gordon, Ph.D., Marianne Henninger, B.A., C.A.C.

Answer Yes or No to the following questions as honestly as you can, thinking specifically of the last six months. Drug use in these questions refers to any chemical substance that has a mood-altering effect. This includes prescription and over-the-counter medications.

Y N Do you like the feeling that alcohol or drugs give you?

Y N Do you look forward to times when you can drink or use drugs without interference, perhaps when your responsibilities are less than usual?

Y N Do you feel that you deserve to have a drink or use drugs to help you unwind in the evening after your work, parenting or other home responsibilities are complete for the night?

Y N Does drinking or drug use make it easier for you to cope with competing demands?

Y N Does drinking or drug use temporarily lessen your loneliness and/or emptiness?

Y N Do you believe drinking or using drugs helps you to fit in socially?

Y N Do you believe drinking or using drugs helps you to cope with a difficult relationship?

Y N Do you have fewer arguments when you are drinking or using drugs?

Y N Does drinking or drug use allow you to more easily express your anger?

Y N Does drinking or drug use soften bad memories and the distress associated with them?

Y N Do you use alcohol or drugs to numb feelings of grief or loss?

Y N Do you drink or use drugs to control your weight?

Y N Do you drink or use drugs to lessen distress about your appearance?

Y N Do you drink or use drugs to numb uncomfortable feelings in sexual encounters?

Y N Do you drink or use drugs to enhance sexual interest or responsiveness?

Y N Does drinking or drug use help you get to sleep more easily?

Y N Does drinking or drug use prevent you from getting restful sleep?

Y N Does alcohol or drug use help take away anxious thoughts and feelings?

Y N Do you believe that alcohol or drug use enhances your intellectual ability or creativity?

Y N Do you drink or use drugs to enhance your work or school performance?

Y N Have you experienced more physical complaints such as chronic pain, gastrointestinal, or gynecological problems since your drinking or drug use has become more regular?

Y N Do you sometimes drink or use more drugs than the limits you set for yourself?

Y N Have you noticed that it takes more alcohol or drugs to achieve the same feeling than it did when you first began your use?

Y N Do you have trouble cutting back on your drinking or drug use?

Y N Do you feel more disconnected from your spiritual self and experience less satisfaction with life?

A YES answer to four or more questions suggests you may have problems with drug or alcohol use. Also, if any of these questions made you feel uncomfortable or question your drug or alcohol use, it is important for you to consider seeking a professional evaluation of your substance use.

This is not a standardized diagnostic instrument and is intended only to provide an initial screening to suggest need for a professional evaluation of substance use.

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